Medical History

Name (Please Print) _____ **Phone #** _____

Date of Birth ____/____/_____ **Height** _____ **Weight** _____ **Gender: M F**

Emergency Contact (Please Print): _____ **Phone #** _____

Do you have a history of the following?
YES / NO Heart attack
YES / NO Heart surgery
YES / NO Cardiac catheterization
YES / NO Coronary angioplasty (PTCA)
YES / NO Pacemaker / implantable cardiac defibrillator / rhythm disturbance
YES / NO Heart valve disease
YES / NO Heart failure
YES / NO Heart transplant
YES / NO Congenital heart disease

Do you have any of the following symptoms?
YES / NO You experience chest discomfort with exertion
YES / NO You experience *unreasonable* breathlessness
YES / NO You experience dizziness, fainting, blackouts. If so explain_____
YES / NO You take heart medications

Please mark ALL true statements
_____You are a male older than 45 years
_____You are a woman older than 55 years or you have had a hysterectomy or you are post menopausal
_____You smoke or have quit smoking within the previous 6 months
_____Your blood pressure is greater than 140 / 90 or you take blood pressure medication
_____Your blood cholesterol is greater than 200 mg /dL
_____You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)

_____You are 20 pounds or more overweight Fitness & Recreation Center bu.edu/fitrec | (617) 353-2748

_____You are physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days/week)
_____You are diabetic
_____You have been diagnosed with kidney disease
_____You have been diagnosed with thyroid or other endocrinological disorder
_____You have respiratory problems, such as asthma, chronic bronchitis, emphysema or COPD
_____You have muscular problems, arthritis, orthopedic problems or have had a previous injury that may limit your physical activity
_____You are pregnant
_____You have a cramping, burning sensation in your lower legs when walking short distances

List all surgeries you've had in the past year. Also list any current joint or muscle issues.

_____
_____
_____
_____
_____

List all medications you take on a regular basis:

Medication	**Reasons**

I understand that I may be undergoing physical exertion while participating in services and activities at or associated with the Boston University Fitness and Recreation Center and I certify that my level of physical fitness is sufficient for the activities in which I choose to take part. In acknowledging that I am aware of and willing to assume the risks associated with these activities and services, I hereby voluntarily agree to waive, hold harmless and indemnify the Trustees of Boston University and its agents, volunteers and employees from any and all claims demands, damages and causes of action of any nature whatsoever arising out of ordinary negligence which I, my heirs, my assigns or successors may have against them for, on account of, or by reason of my voluntary participation in services and activities at or associated with the Boston University Fitness and Recreation Center. I understand the content of this document, and I execute this INFORMED CONSENT AND WAIVER OF CLAIM FORM of my own free will and accord.

Name of Participant (Print): _____

Signature of Participant: _____Date:_____

Signature of Parent or Guardian (If under 18 years of age): _____
YES / NO I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

Signature: _____ Date: _____